System Change Form: Change in System Ownership

Delaware Certification Number DE-98374-SUN-01-OW

Facility Name Mays Power

System Address 6 Aronimink Court, Dover, DE 19904

Contact Person Marilyn Mays

Seller Name _____

Buyer Name Marilyn Mays

Buyer Phone Number 302-678-1582

Buyer email address hearyoudoc@hotmail.com

Buyer Mailing Address _____

Ownership Change (please check which one applies)

- ○ Change in System Ownership only
- ○ Change in SREC Ownership only
- ☒ Change in System and SREC Ownership

Same owner - widow no other changes, only the first name from Doreen to Marilyn Mays

Date of sale/change of ownership 05/19/2016

Signature of Seller _____

Signature of Buyer _____

I, MARILYN MAYS (print name) hereby certify under penalty of perjury that:

The statements above are accurate; and

If any of the representations made in this form or in any amendment thereto are found to be untrue when made, I/the company may be subject to sanctions, including but not limited to monetary fines and/or the revocation of any Delaware Certification number granted as a result of the representations made.

Name MARILYN MAYS

Date 5/22/17

Signature Marilyn Mays

H105.805 REV (9/11)

LOCAL REGISTRAR'S CERTIFICATION OF DEATH

WARNING: It is illegal to duplicate this copy by photostat or photograph.

Fee for this certificate, $6.00

This is to certify that the information here given is correctly copied from an original Certificate of Death duly filed with me as Local Registrar. The original certificate will be forwarded to the State Vital Records Office for permanent filing.

P 22911985
Certification Number

Maria DeFeo
Local Registrar

MAY 23 2016
Date Issued

Type/Print In Permanent Black Ink

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

State File Number:

1. Decedent's Legal Name (First, Middle, Last, Suffix)	2. Sex	3. Social Security Number	4. Date of Death (Mo/Day/Yr) (Spell Mo)
LOREN A MAYS	M	222-30-1879	May 19, 2016

5a. Age-Last Birthday (Yrs)	5b. Under 1 Year: Months	Days	5c. Under 1 Day: Hours	Minutes	6. Date of Birth (Mo/Day/Year) (Spell Month)	7a. Birthplace (City and State or Foreign Country)	7b. Birthplace (County)
69					July 4, 1946	Wilmington, Delaware	New Castle

8a. Residence (State or Foreign Country)	8b. Residence (Street and Number - Include Apt No.)	8c. Did Decedent Live in a Township?
Delaware	6 Aronimink Court	☐ Yes, decedent lived in _____ twp.
8d. Residence (County)	8e. Residence (Zip Code)	☒ No, decedent lived within limits of Dover city/boro.
Kent	~~19904~~	

9. Ever in US Armed Forces?	10. Marital Status at Time of Death	11. Surviving Spouse's Name (If wife, give name prior to first marriage)
☐ Yes ☒ No ☐ Unknown	☒ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown	Marilyn Elaine Burnham

12. Father's Name (First, Middle, Last, Suffix)	13. Mother's Name Prior to First Marriage (First, Middle, Last)
Harold Mays	Mildred Hawke

14a. Informant's Name	14b. Relationship to Decedent	14c. Informant's Mailing Address (Street and Number, City, State, Zip Code)
Marilyn Mays	wife	6 Aronimink Court, Dover, DE 19904

15a. Place of Death (Check only one)

If Death Occurred in a Hospital: ☒ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

If Death Occurred Somewhere Other Than a Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify) _____

15b. Facility Name (If not institution, give street and number)	15c. City or Town, State, and Zip Code	15d. County of Death
Hospital of the University of Pennsylvania	Philadelphia, PA 19104	Philadelphia

16a. Method of Disposition	16b. Date of Disposition	16c. Place of Disposition (Name of cemetery, crematory, or other place)
☒ Removal from State ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) _____	May 23 2016	Hockessin Crematory Company

16d. Location of Disposition (City or Town, State, and Zip)	17a. Signature of Funeral Service Licensee or Person in Charge of Interment	17b. License Number
Hockessin, DE 19707	[signature]	138932

17c. Name and Complete Address of Funeral Facility
Chandler Funeral Home, 2506 Concord Pike, Wilmington, DE 19803

To Be Completed/Verified By: FUNERAL DIRECTOR

18. Decedent's Education - Check the box that best describes the highest degree or level of school completed at the time of death.
- ☐ 8th grade or less
- ☐ No diploma, 9th - 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☒ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

19. Decedent of Hispanic Origin - Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
- ☒ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

(Specify) _____

20. Decedent's Race - Check ONE OR MORE races to indicate what the decedent considered himself or herself to be.
- ☒ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Other (Specify) _____
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

21. Decedent's Single Race Self-Designation - Check **ONLY ONE** to indicate what the decedent considered himself or herself to be.
- ☒ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Don't Know/Not Sure
- ☐ Refused
- ☐ Other (Specify) _____

22a. Decedent's Usual Occupation - Indicate type of work done during most of working life. DO NOT USE RETIRED.
Pharmacist

22b. Kind of Business/Industry
Medical

ALIAS USED _____

To Be Completed By: MEDICAL CERTIFIER

ITEMS 23a - 23d MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH	23a. Date Pronounced Dead (Mo/Day/Yr)	23b. Signature of Person Pronouncing Death (Only when applicable)	23c. License Number
23d. Date Signed (Mo/Day/Yr)	24. Time of Death	25. Was Medical Examiner or Coroner Contacted? ☐ Yes ☒ No	
	05/19/2016		
	12:15		

CAUSE OF DEATH

26. **Part I.** Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) ---------->	a. Embolus, pulmonary	24 day(s)
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**.	b. Malignancy	445 day(s)
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	
	Due to (or as a consequence of):	

26. **Part II.** Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Was an autopsy performed? ☐ Yes ☒ No

28. Were autopsy findings available to complete the cause of death? ☐ Yes ☒ No

29. If Female:
- ☐ Not pregnant within past year
- ☐ Pregnant at time of death
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Unknown if pregnant within the past year

30. Did Tobacco Use Contribute to Death? ☐ Yes ☐ Probably ☒ No ☐ Unknown

31. Manner of Death
- ☒ Natural
- ☐ Accident
- ☐ Suicide
- ☐ Homicide
- ☐ Pending Investigation
- ☐ Could not be determined

32. Date of Injury (Mo/Day/Yr) (Spell Month)

33. Time of Injury

34. Place of Injury (e.g. home; construction site; farm; school)

35. Location of Injury (Street and Number, City, County, State, Zip Code)

36. Injury at Work ☐ Yes ☐ No

37. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____

38. Describe How Injury Occurred:

39a. Certifier - physician, certified nurse practitioner, medical examiner/coroner (Check only one):
- ☐ Certifying only - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
- ☒ Pronouncing & Certifying - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
- ☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of certifier: [signature] Title of certifier: MD License Number: MT205769

39b. Name, Address and Zip Code of Person Completing Cause of Death (Item 26)
LU, DANIEL Y 3400 SPRUCE ST. PHILA, PA 19104

39c. Date Signed (Mo/Day/Yr)
5/19/2016

40. Registrar's District Number
23-233

41. Registrar's Signature
Maria DeFeo

42. Registrar File Date (Mo/Day/Yr)
May 23, 2016

43. Amendments

NAME OF DECEDENT LOREN A MAYS

Disposition Permit No. 1315682

H105-143
REV 07/2012